



**SOUTHERN**  
*health & social services*  
**COUNCIL**

# **Patients' Experiences of Using General Dental Services**



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<b>Contents:</b>		<b>Page</b>
1	BACKGROUND TO THE REPORT	3
2	INTRODUCTION	4
3	THE POLICY CONTEXT	4
4	THE FOCUS GROUPS	5
5	THE METHODS USED	7
6	THE FOCUS GROUP DISCUSSIONS	7
6.1	General Care and Quality of Service	7
6.2	Accessibility and Location	8
6.3	Charges, Visits, and Convenience of Appointments	9
6.4	Information and Advice	10
6.5	Participants' Experiences of Good Services	11
6.6	Focus Groups' Suggestions for Change	11
7	THE STEP FOCUS GROUPS	12
8	CONCLUSIONS	13
9	RECOMMENDATIONS	13



## 1. BACKGROUND TO THE REPORT

As a participant in the review of the Primary Care Dental Services strategy undertaken by the Department of Health & Social Services and Public Safety, the Southern Health and Social Services Council (SHSSC) was keen to ensure that the strategy, which will determine the future delivery of dental services, should encompass the views and experiences of people who use primary care dental services (high street dentists).

The development of the strategy included a series of focus groups, organised in conjunction with the DHSSPS, for the dental profession to explore a number of models for the future delivery of dental services in Northern Ireland. The SHSSC felt that this process should be mirrored in order to provide information on the views and experiences of the people who use the services. This report was commissioned by the SHSSC to order to gather this information and share it with the PCDS Project Board.

It is anticipated that the strategy will be consulted upon over the autumn of 2005 and the SHSSC believes that this document will make a contribution in stimulating community interest this important issue. The findings of the report and a further community consultation event to be carried out by the SHSSC will form the basis of our response to the strategy consultation. We also hope that the information contained in the report will provide a useful resource to others interested in responding to the consultation.

We would like to thank everyone who was involved in the production of this report, particularly all the participants of the focus groups who shared their experiences so willingly.

**Stella Cunningham**

Chief Officer

Southern Health & Social Services Council

## 2. INTRODUCTION

Plans to examine the issue of access to General Dental Services (GDS) were included in the Southern Health and Social Services Council's 2003/2004 work programme but the project was postponed because of competing pressures on the Council's resources.

In late 2004 the DHSSPS commenced the task of developing a strategy for the delivery of Primary Dental Care Services for Northern Ireland over the next 10 years. The four Health and Social Services Councils were represented on the Strategy Project Board by the Chief Officer of the Southern Health and Social Services Council (SHSSC). With a view to informing the Councils' contribution to development of the strategy the SHSSC commissioned D&D Consultancy to convene a series of focus groups throughout the Southern Board area to explore the experience of patients and their families in using General Dental Services.

## 3. THE POLICY CONTEXT

The first Northern Ireland Oral Health Strategy was published in 1995 and revised in 1998 following a decision not to proceed with the fluoridation of the water supply. The mid term evaluation of the strategy published in 2001 showed evidence of overall improvements in the oral health of the population of Northern Ireland but indicated an enduring problem of oral health inequalities linked to deprivation and disadvantage.

Prior to 2005 a national General Dental Services contract applied in all four countries of the UK. The new contractual arrangements introduced in April 2005 apply to England and Wales only, leaving Northern Ireland, like Scotland, with the task of developing its own contractual arrangements for the delivery of General Dental Services.

Against this background the DHSSPS decided to:

- Develop a new Oral Health Strategy. The consultation document on the strategy was issued in September 2004.
- Develop a strategy for the delivery of Primary Care Dental Services. The strategy is expected to support the process of decision making on how dental services should be delivered to the public, and on the contractual arrangements needed to ensure an effective and efficient General Dental Service.

The DHSSPS published its public health strategy *Investing for Health* in 2002. The focus was on tackling health inequalities through a partnership approach, recognizing that achieving health gain requires action by a wide range of agencies other than the health service. The *Oral Health Strategy* seeks to build on and contribute to the *Investing for Health strategy*.

*Priorities for Action* is the process through which the Government's priorities are translated into targets for action on the part of Boards and Trusts. *Priorities for Action 2004/2005* included targets in relation to increasing the numbers of under - 5's registered with general dental practitioners, and improving the oral health of children in the most disadvantaged areas.

Northern Ireland's new 20-year regional health and well being strategy *A Healthier Future* was published in January 2005. It emphasized the need for services to be accessible, particularly to those with the greatest health need. The 2004 Oral Health Strategy Consultation document points to substantial evidence that in relation to oral health those with the greatest need have the lowest level of service utilization.

*A Healthier Future* also emphasized the need for patient and public engagement in relation to decision making processes in the health service, and the positive outcomes that can be expected at an individual level where service users and health practitioners work in partnership.

In seeking the views of local communities in order to influence the development of the Primary Dental Care Services strategy the SHSSC is fulfilling its remit to represent the views of service users and is contributing to the implementation of HPSS policy directives in relation to public and patient engagement in decision making processes.

#### 4. THE FOCUS GROUPS

The purpose of the focus group exercise was to sample the views of people from communities throughout the Southern Health and Social Services Board area on their experience of using General Dental Services (GDS).

The remit given to the consultants by the SHSSC was to organise and facilitate a series of focus groups whose membership would reflect as far as possible the diversity of the population in the southern area, and be reflective of the different geographical areas. Within the limits imposed by the resources available and the timeframe for the consultation process, the aim was to ensure representation from all sections of the community including minority ethnic communities, women's groups, men's groups, older people and families living with disability.

The geographical areas for the focus groups were selected to ensure that participants from all three Community Health and Social Services Trust areas were included, and to give opportunities for participation from both Protestant and Catholic communities. Efforts were also made to ensure that both urban and rural communities were involved.

Contact was made with a number of community groups from throughout the Southern area who were invited to act as hosts for the focus groups and to encourage attendance from within their membership and the membership of neighbouring groups. From among the community groups who volunteered to participate the following were selected with a view to achieving the necessary community and geographical balance.

<b>Group</b>	<b>Interests represented</b>	<b>Trust Area</b>
Women and Family Health Initiative, South Armagh	Families and young children. Women. Rural areas. Disabled. Mental health.	Newry and Mourne
South Tyrone Empowerment Project (STEP) Dungannon	Ethnic minorities. Low paid workers. Urban areas.	Armagh and Dungannon
Senior Citizens Consortium	Older people. Urban and rural areas.	Newry and Mourne
TASSK Men's Health Group Banbridge	Men. Urban areas.	Craigavon and Banbridge
Ageing Well	Older people. Urban areas. Cross community	Craigavon and Banbridge
Middletown Community Association	Families and all age groups. Rural areas	Armagh and Dungannon
Chrysalis Women's Centre, Brownlow	Women and young families. Disadvantaged urban areas. Disability and mental health.	Craigavon and Banbridge

A total of nine focus groups were conducted. STEP made arrangements for two focus groups; one was a group of Portuguese speaking people where the facilitators worked through an interpreter while the second was comprised of migrant workers from different ethnic backgrounds who had English as a second language. The experiences of the STEP group participants and the issues they

raised differed significantly from the views expressed by the other seven focus groups. For this reason the outcome of the STEP focus group discussions is reported on separately in the commentary later in this report.

Originally it had been intended to organise a focus group with members of the Traveller community but this proved not to be feasible within the timescale available for the project.

### 5. THE METHODS USED

Discussions were held with leaders of the seven participating community groups to agree the methods to be used to facilitate discussion and the format of the materials used to introduce the topics for discussion.

The seven focus groups were conducted during the period February to April of 2005. Attendance at the group secessions varied from two to 53 but in all 119 people participated in the consultation exercise.

A similar format was used for each of the groups. Participants were given information on the purpose of the focus group, and on the role of the SHSSC as commissioner of the exercise. The facilitators presented background information on how NHS dental care services are organised and delivered and some pointers to patients' rights and entitlement. Focus group participants were then invited to share their experience and views on the following topic areas:

- General care and quality of service
- Accessibility and location of General Dental Services
- Charges; arrangements for visits; convenience of appointments
- Information and advice
- Good services and experiences
- Ideas for the future

### 6. THE FOCUS GROUP DISCUSSIONS

#### 6.1 General Care and Quality of Service

Most participants found the manner and attitude of dentists to be courteous and caring. Some very positive experiences regarding the treatment of children were recounted. Premises were mainly user friendly with thought given to meeting family needs.

Many people, however, were unsure of what they should expect from their dentist in terms of quality and standard of dental work, and what steps they could take to

determine how good their dentist really is. The opportunity to access objective information on the overall performance of dental practices would be welcomed. In general participants made their choice of dentist on the recommendations of friends and neighbours. Where problems were encountered and work had to be repeated, participants were unsure what their rights were. It was difficult for patients to be confident that equipment used was properly maintained, particularly where older equipment was still in use.

Many people reported that with their regular dentist they were generally able to access treatment at short notice in an emergency. However, there was a general lack of awareness of the arrangements for providing out of hours care, including the hospital based pain relief service.

While the process of signing documentation every 15 months was familiar to many, there was little understanding of the purpose of registration or its importance in terms of accessing services. Some dentists regularly reminded patients of the need to attend for a check up, but some participants reported receiving such notices irregularly. There was no evidence of any heightened awareness regarding registration among mothers of young children who participated in the focus groups, which may have implications for achieving the targets included in *Priorities for Action 2004/05*.

Concern was expressed at the lack of continuity of care, with some people seeing a different dentist on virtually every visit.

Fear of the dentist remains an issue for some patients. The dental surgery can be seen as a very disempowering environment where people feel vulnerable. This is compounded where people feel they are being 'lectured to' or blamed for their poor oral health. Some participants from more disadvantaged areas viewed dentists as favouring extraction over other treatment methods. There was an acknowledgement that some people give low priority to oral health but that it has significant implications for the general health of the individual.

Most participants saw the need for a greater focus on oral health promotion, including a focus on the impact of nutrition on the health of the teeth.

### **6.2 Accessibility and Location**

In general focus group participants were able to access NHS General Dental Services, although in some areas this proved easier than in others. There were some examples of where practices were accepting only children and those exempt from charges as NHS patients.

While the option of travelling to nearby towns and villages for NHS treatment appeared to be an option, in all such cases this caused difficulties for those relying on infrequent public transport services.

Routine appointments are not available during evenings and weekends so where patients have to take time off work, and travel to an outlying practice, accessing dental services can be prohibitively expensive.

There was no awareness among participants of the availability of home visits for patients who live within the catchments area of their dentist and who are unable to travel to the surgery.

Some towns and villages offered a significantly greater choice of dental practices than others, reflecting the fact that General Dental Service provision is influenced by market forces rather than health service planning processes.

Newer dental practices tend to have more modern ground floor premises with adequate disabled access, but many others are situated on upper floors of buildings giving rise to problems of physical access for people with disabilities and for mothers of young children and babies. However, where ease of access was a requirement, group participants generally reported being able to choose to use a practice which offered the facilities they required.

Proximity to parking facilities was also reported as a problem for people with disabilities, even where the access facilities in the practice premises were good.

### **6.3 Charges, Visits, and Convenience of Appointments**

Across all the focus groups there was little awareness of the costs of dental treatment, with some participants uncertain about whether they were being treated as an NHS or private patient. Similarly the level of knowledge about the proportion of the total costs paid by the patient accessing treatment under the NHS scheme, the threshold for the amount payable for any one course of treatment, or the range of treatments available under the NHS was virtually non-existent among focus group participants.

There was little evidence from the focus group discussions of patients being given a treatment plan with associated estimates of costs prior to commencing treatment.

Concern was expressed at the possibility that the method of remunerating dentists for NHS work could result in items of treatment that were not strictly necessary being carried out.

While some participants reported that their practice displayed the costs of items of treatment in the premises, most had no recollection of seeing such notices. Patients reported feeling vulnerable around the issues of charges, particularly where these were discussed during treatment rather than estimated in advance as part of a treatment plan. Where patients requested estimates in advance these were provided by their dentist.

Some participants reported that fear of charges resulted in the postponement of plans for essential treatment. In general participants regarded dental treatment as expensive, although some examples provided of costs incurred suggested that these referred to private rather than NHS treatment.

Concern was expressed at the situation of low income groups such as students or pensioners who are not entitled to free treatment on the basis of receipt of passport benefits. In none of the nine focus groups was any awareness expressed of the availability of help through the social security system for people on low income but not in receipt of the passport benefits.

The experiences related regarding the booking of appointments varied across the focus groups. While many practices were able to offer emergency appointments at very short notice, waiting times of 6 to 8 weeks for routine appointments were common. A few participants reported even greater difficulty in booking appointments where practices exercised their right to partially opt out of the provision of NHS treatment. While all dentists in the Southern area offer NHS treatment for children, participants reported difficulty in arranging NHS appointments for young people in the 12+ age groups. Waiting times for referral to orthodontic services were reported as a major cause for concern with waiting times of up to 2 years a common experience.

### 6.4 Information and Advice

The focus group discussions are suggestive of a high level of interest in receiving accurate information related to promoting oral health. Many participants would like to have more time to discuss oral health generally, including preventative measures and options for treatment with their dentist.

The view of participants was that health information provided by dental practices should be holistic and integrated with general health promotion messages on issues such as nutrition. Although General Dental Service contracts allow little scope for the provision of health information, many dentists provided significant levels of advice and information, although this varied from practice to practice.

Some participants were reluctant to ask for advice and information, aware of the pressure on dentists and the fear that seeking advice might cause delays for other patients waiting for their appointments. Suggestions for improving the delivery of health promotion information included making better use of information leaflets, using dental support staff to undertake this role, and the use of information videos in waiting areas to promote health messages.

The need for information targeted at young people on the threat to dental health from sugar laden sports drinks and other heavily advertised products was emphasised. Some participants indicated a need for better information and advice on issues such as how to make a complaint or the advisability of frequent x-rays.

For people without natural teeth information on the use and care of dentures, and on whole mouth health, was also emphasised by participants in one group.

## **6.5 Participants' Experiences of Good Services**

Focus groups participants were specifically asked about examples of what they considered to be particularly good practice in relation to the provision of General Dental Services. Some participants were appreciative of their dentists' efforts to accommodate them with arranging appointments after school hours, a time when practices are under particular pressure in relation to appointments. Others cited the practice of providing reminders about appointments or the need to renew registration, although this practice was far from universal.

Examples were also provided of dental practices which provided particularly good facilities for children, including providing toys for use by younger children. Other participants expressed their appreciation of their dentist's skills in dealing with fearful adults and making them feel at ease. The provision of health information material and advice, the mouth guard promotion, and the availability of emergency treatment after hours were also cited as examples of practices which were particularly appreciated. While few participants had experience of dentists providing routine appointments outside of normal opening hours this was rated highly by those who had the opportunity to avail of this service.

Reference was made to how difficult it was for patients to measure what constituted good clinical practice and the need for more evidence of government checks on the quality of NHS General Dental Practice.

## **6.6 Focus Groups' Suggestions for Change**

Focus group participants suggested a number of courses of action aimed at improving the organisation of General Dental Services or promoting good oral health. These are summarised as follows:

- The funding of General Dental Services should be changed to allow dentists to be rewarded for maintaining patients' oral health rather than being paid for each procedure carried out. Practices should have a greater role to play in health promotion.
- There should be more integration of GP and GDS services, which could be facilitated if they shared premises
- Emphasis should be placed on promoting oral health to the wider community, involving community/sports/youth groups in preventative work using a positive approach. The impact of the advertising of unhealthy products to young people should be examined.
- Additional support should be available for older people on low incomes who do not currently qualify for free NHS dental services

- Where patients opt for treatment not available on the NHS the system should allow them to carry forward the cost of their NHS entitlement and pay the balance of the cost of private treatment

### 7. THE STEP FOCUS GROUPS

Participants in the Portuguese speaking group were workers who had come to the Dungannon area to take up employment in local factories. The second group included workers from a range of ethnic and linguistic backgrounds who were either in employment in local factories, or worked as interpreters or in other support roles with the communities supported by the STEP project.

Participants reported difficulty in registering for NHS services in the Dungannon area with some reported travelling as far as Omagh in order to access services. With a shared experience of low paid employment they regarded dental service costs as particularly expensive.

Coming from countries with very different arrangements for health service provision many regarded the need to first register with a GP in order to be eligible for NHS dental services as unnecessarily cumbersome. Problems were experienced where patients required dental treatment while awaiting the completion of the CSA registration process.

Participants faced significant difficulties in gaining information on the structure of the health and social care system in Northern Ireland and on their entitlements to services. The language barrier added significantly to these difficulties. Despite the investments by the Trust, Board and Government departments in the development of interpreting services group participants had no experience of such services being available to support their access to the services of their GP or dentist.

Two trained interpreters who participated in the groups were not aware of any opportunities to use their skills to improve access to services for Portuguese speaking patients. Interest was expressed in the provision of simple guides to all NHS services, including dental service, in a variety of relevant languages. This could play a part in countering what was seen as disinformation from some employers who stood to gain from discouraging workers from exercising their rights to avail of NHS services.

Group participants were highly motivated towards accessing quality dental services both for themselves and for their children. Nevertheless, there was little awareness of the fact that children were entitled to free NHS treatment.

Many group participants worked long hours and this presented problems in accessing services that have limited opening hours. Generally time off to attend medical or dental services was unpaid so attendance was often limited to where serious problems existed.

With regard to recommendations for change the priorities for participants in the STEP groups included:

- Access to interpreters when attending for dental services
- The provision of information leaflets on the health service generally, and on dental services specifically, in the relevant languages. This includes information on health promotion
- Access to information on how to access emergency dental services
- Access to accurate information on charges for services

### 8. CONCLUSIONS

There is evidence from the focus group discussions that communities in the Southern area:

- take the issue of oral health seriously;
- that they are conscious of the impact of oral health on their health status generally;
- and that they strongly support the idea of placing a greater emphasis on preventative measures.

The experience reported of using General Dental Services was a positive one, with focus group participants voicing their appreciation of the professionalism, attitude and approach of the practitioners with whom they had contact.

There was a low level of awareness among participants on how the NHS General Dental Services were organised and structured, and on their entitlements as patients in relation to NHS treatment.

The rights of ethnic minority groups to NHS services are compromised by the lack of provision of interpreting services and of information leaflets in relevant languages.

### 9. RECOMMENDATIONS

- 9.1 The system whereby GDS practitioners are paid per item of treatment should be revised. Contracts should reward practitioners for maintaining the general oral health of patients and providing health information and advice.
- 9.2 GDS contracts should allow for adequate time for appointments to ensure an appropriate balance between treatment and the provision of advice and information.

- 9.3 Health promotion agencies should involve community organisations, sports groups and youth organisations in a campaign to improve the oral health of the population of Northern Ireland. The role of the food and drinks industry should be recognised and consideration given to introducing controls on the promotion of unhealthy products to children and young people.
- 9.4 A code of practice should be developed for GDS practitioners that requires practices to:
- Clarify to prospective patients their policy in relation to the provision of NHS and private treatments.
  - Display clear information on the costs of common items of treatment.
  - Provide patients with a treatment plan and estimate of costs prior to commencing a course of treatment.
  - Produce a practice leaflet indicating the range of services provided, including information on any specialist services available.
- 9.5 The DHSSPS should examine the feasibility of introducing a system whereby patients could retain their NHS entitlement while paying an additional element for treatments not available on the NHS.
- 9.6 GDS practices should be encouraged to provide flexible opening hours to meet the needs of patients in employment.
- 9.7 Where feasible GDS services should be integrated with other primary care services, but particularly with GP services.
- 9.8 Information on the help available with dental charges through the social security system for people on low incomes should be prominently displayed in all premises where NHS GDS services are provided.
- 9.9 Interpreting services should be provided to support access to GDS services for minority ethnic groups. Information leaflets in relevant languages should be made available. Contracts should require practices providing NHS GDS services to ensure that the needs of their minority ethnic patients are catered for.
- 9.10 GDS practices should be required to comply with the requirements of the Disability Discrimination Act which came into effect in October 2004.
- 9.11 Action should be taken to reduce the waiting times for orthodontic treatment.

9.12 The planned Primary Dental Care Strategy should recognise that tackling oral health inequalities requires the planned targeting of General Dental Services towards areas of greatest need as opposed to the current system where investment is influenced predominantly by market forces.

**Deirdre Blakely**  
**Delia van der Lenden**

**Dental Project Focus Groups**

Middletown Community Association, Middletown

Women and Family Health Initiative, Mullaghbawn

Senior Citizens Forum + 3A club, Newry

Ageing Well, Lurgan

STEP Portuguese speakers, Dungannon

Step English speakers, Dungannon

TASSK HLC, Banbridge

Chrysalis Resource Centre, Craigavon



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